New England Deaconess Hospital

pulse

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Transplants give renal patients hope for improved quality of life

(This is the final installment of a three-part series on NEDH renal services)

'Transplants are a form of treatment, not a cure,' is the first fact emphasized to people who come to the Deaconess Hospital to inquire about receiving a *kidney (renal) transplant.**

"Many people think that a transplant not only will free them from *dialysis* machines, but also will solve any financial, emotional, marital or health problems they might have," said Renal Transplant Nurse Patricia Conway. "We all have our fantasies and dreams. I represent reality to them."

Although a transplant does not guarantee dramatic improvements in all areas of a person's life, it does free people with *renal failure* from time-consuming, and sometimes discomforting, dialysis treatments. A transplant can give a person an extra incentive to manage his medical condition, additional energy for work and family life, and the opportunity to maintain a more "normal" lifestyle.

*All italicized words are defined in a glossary on page 4.

John Pozark, 49, made his decision to seek a transplant when he was receiving hemodialysis at the Deaconess two years ago. "The nursing staff brought together dialysis patients who were awaiting transplants with people who had undergone the surgery so we could find out what we were getting into," remembers Pozark. "Just hearing a woman say, 'I can dance again,' gave me the incentive to try for a transplant." Pozark received a cadaver transplant last March, but his body rejected the kidney three months later. Pozark, who has *diabetes,* currently is on a waiting list for a second kidney. "You have to expect that your body might reject the kidney," he said. "It's just the chance you take."

Ten years ago, Pozark probably would not have had the opportunity to receive a transplant. In the early 1970s, people with diabetes were not considered good candidates for renal transplantation because their disease often leads to cardiovascular complications which can endanger the success of a transplant. People with diabetes also have problems tolerating the strong *immunosuppressive drugs* needed to prevent rejection of the kidney. With medical advancements over the past ten years, diabetes is no longer considered an insurmountable obstacle in seeking a transplant.

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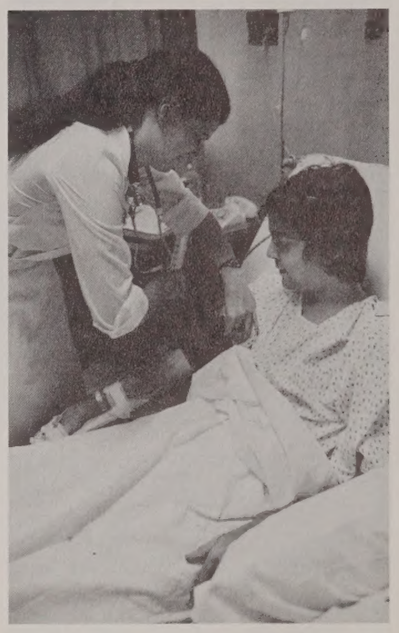


Caroline Hastie, RN, checks the blood pressure of Richard Fuller, a patient in the renal cluster unit on Palmer 2.

Annual meeting offers review of past year; outlines changes facing NEDH

Trustees, corporators, administrators and Friends of the Deaconess attended the NEDH 1983 Annual Meeting of the Corporation on January 18 in Joslin Auditorium to review hospital achievements during 1982, to learn of the implications of Chapter 372, and to hear about national health care financing proposals.

Marvin G. Schorr, chairman of the NEDH Board of Trustees and president of Technical Operations, Inc., presided over the business session, which included remarks by President Laurens MacLure and reports by A. Richard Christlieb, MD, chairman of the medical administrative board; James F. Morgan, treasurer of the board of trustees; Robert J. Spiller, chairman of the board's audit committee; Mary Eliza McDaniel, president of the Friends of the Deaconess.

During this session, *Joseph D. Hamilburg,* senior vice president of the Plymouth Rubber Company, was elected to the corporation membership, and three people were elected to the board of trustees: *Charles L. Smith Jr.,* managing partner at State Street Research and Management and a current vice chairman of the board; *C. Vincent Vappi,* president of Vappi & Company; *Hillard W. Welch,* president of International Ophthalmic Industries, Corporation.

Two trustees retiring from the board received gifts from the hospital as a token of appreciation for their service: *F. Thayer Sanderson Jr.,* executive vice president of the Shawmut Bank of Boston, a trustee for ten years; and *William B. Tyler,* partner in the Rackemann, Sawyer and Brewster law firm, a trustee for 13 years. Both men will remain as members of the corporation and will be active on trustee committees.

Mary Eliza McDaniel, president of the Friends of the Deaconess, presents a check for $50,000 to Marvin G. Schorr, chairman of the board of trustees.

Mary Eliza McDaniel, president of the Friends of the Deaconess, presented a $50,000 check to the hospital for the purchase of a computer and lung module for the pulmonary laboratory, and a gift of $3,952 for renovation of the solarium on Baker 5. McDaniel also announced that in 1982 the Friends gave $12,743 to the NEDH School of Nursing — the cost of a full, three-year scholarship.

In turn, Schorr presented the Friends with a plaque from the hospital commemorating the group's 50 years (1932-1982) of continuous service and support, thanking them for the $1,300,000 they had donated to the hospital during that time.

In his report at the annual meeting, Dr. Christlieb highlighted medical, teaching and research accomplishments of the past year, including expansion of the department of medicine in infectious and vascular diseases and hematology, and the establishment of a separate anaesthesia department. The department of medicine also has the

(continued on page 3)

Change in PULSE publication schedule

Beginning with this issue, the publication frequency of PULSE has been changed from monthly to bimonthly. This action has been taken in order to decrease overall production costs and to make more effective use of limited resources in its preparation.

The new publication frequency will result in PULSE issues of eight to ten pages in length, and will provide an opportunity for more comprehensive coverage of the hospital — its medical specialties, patient care services, personnel and general activities, as well as the external forces and events which directly affect the Deaconess.

Every effort will be made to maximize the effectiveness and timeliness of PULSE as the hospital's primary news and feature publication, and to offer all readers a consistently interesting variety of material related to the Deaconess community.

The editorial staff continues to welcome the comments and suggestions of PULSE readers, and these may be directed to the PULSE Managing Editor, Public Relations Department, New England Deaconess Hospital, 185 Pilgrim Road, Boston, Massachusetts 02215.

Friends' bazaar, hospital party for employees and their families, brighten winter season for all

Decisions, decisions . . .

NEDH personnel department hosts hospital-wide holiday party for employees and their families

Friends of the Deaconess sponsor annual Christmas Bazaar to benefit the School of Nursing

←

Friends of the Deaconess, Blossom Dick (l) and Marie Rowbotham wrap purchases for bazaar visitors.

Assistant Director Hubert D. Sycamore joined other administrators in serving guests at the holiday party.

Concerts entertain School of Nursing visitors

Conductor John J. Markarian leads the Student Nurses Glee Club during their Christmas concert held at the School of Nursing.

Associate Director and Director of Nursing Ellen D. Howland hosted her annual Christmas Coffee at the School of Nursing where guests enjoyed refreshments and a performance by the Westwood High School Glee Club.

Dr. Roger C. Graves, associated with NEDH for 50 years, dies at age 93

The Deaconess community was saddened by the death of a long-time staff member, friend and supporter, Dr. Roger Colgate Graves, 93, on February 19.

A urologist affiliated with the Deaconess for 52 years, Dr. Graves took a special interest in the hospital's residency training program. He served as urologist in the surgical division of the general staff, in addition to being clinical professor of urology at Tufts College Medical School and urologist-in-chief at the Carney Hospital. An author of more than 60 scientific papers, Dr. Graves made significant contributions to the field of urological surgery.

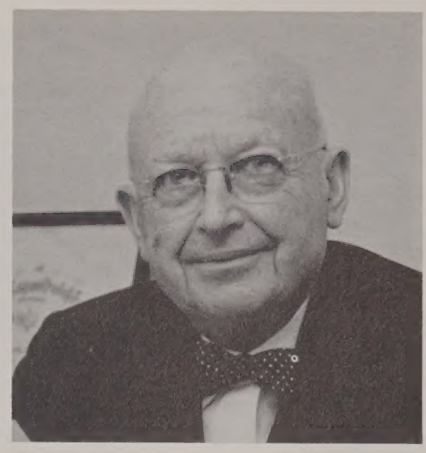
Dr. Graves was a moving force behind the establishment of an affiliation with the Harvard Medical School and the development of a formal medical training program at the Deaconess. He served as the first chairman of the advisory committee for medical education. In 1968, the medical administrative board renamed the surgical teaching service on Palmer 2, the Roger C. Graves Unit, in recognition of Dr. Graves' contributions to the hospital's teaching program.

Upon his retirement in 1974, Dr. Graves was made a member of the honorary staff, and on that occasion he noted, "that there are three great professions above all others that challenge a man — medicine, ministry and teaching. And each of them, especially medicine, should embody something of the other two."

Dr. Graves' tireless dedication to the Deaconess was symbolized recently when he and his son, Charles Moore Graves, presented their family heirloom — a grandfather clock — to the hospital in his wife's memory. "We are pleased to give this clock to the Deaconess because, like the Deaconess, it has been a close and good friend to us for many years," said Charles Graves during a ceremony in the Harris Hall Livingroom.

The clock, which now stands in the livingroom, originally was given to Graves' maternal grandfather, Charles E. Moore, by an appreciative employee in 1913. It was handed down to Graves' mother, Hazel Moore Graves, and then to himself.

"Hazel loved young people," said Dr. Graves at the ceremony, "and in this hospital, young people from all over the world come for training in all areas of medicine and nursing. The name of Hazel Graves will be known only by the clock's name plate," Dr. Graves continued, "but I know that my years of service to the Deaconess were possible only because she was willing to surrender my company. The clock's chimes will be heard by hundreds of people and will remind them that time rules our lives and every minute is precious."



Dr. Roger C. Graves

Joining the late Dr. Roger Graves and his son, Charles Graves, for the presentation and dedication of the Hazel Moore Graves Memorial Clock were: (l-r) Gail E. Graham, staff assistant to the director; Ellen D. Howland, RN, associate director and director of nursing; (Dr. Roger Graves, Charles Graves); Mary Eliza McDaniel, president, Friends of the Deaconess; Roger A. Perry Jr., associate director.

Trustee John F. Keane (l) and his wife, Marilyn, joined President Laurens MacLure at the annual meeting reception.

Chairman of the Board Marvin G. Schorr presents a gift to retiring trustee, F. Thayer Sanderson Jr.

Annual meeting *(continued from page 1)*

largest residency training program in New England. Dr. Christlieb reported that 52 kidney transplants had been performed at the Deaconess, and that the dialysis and home dialysis programs had expanded, making the Deaconess renal transplant group leaders in their field in New England.

The department of radiology is achieving national recognition for its work in nonsurgical diagnostic and treatment for gallstones, hardening of the arteries and stroke, according to Dr. Christlieb, and the department of radiation therapy has treated 41 patients with intraoperative radiotherapy (radiation therapy is performed during surgery without moving the patient from the operating room).

Addressing the future of the Deaconess Hospital, President Laurens MacLure spoke to "The Challenges Ahead" that the hospital will face under Chapter 372, the new, three-year, prospective payment system for hospitals in Massachusetts. This approach replaces a retrospective, cost-based system. Under Chapter 372, hospitals will have to work with the Maximum Allowable Cost (MAC) system which, under third-party payors, will reimburse hospitals a predetermined amount for services. The MAC system already has been implemented by Blue Cross, but now all third-party payors are under the same system.

A powerful incentive for NEDH to cut costs during the first year, said MacLure, is that if the hospital can hold its total expenses below the maximum allowable amount, it can keep the savings into years two and three. If costs exceed the MAC, however, there is no reimbursement for the excess.

"The radical changes brought about by Chapter 372 in Massachusetts are not unique," MacLure emphasized, "but rather reflect concurrent trends nationally as well as in other states." These new national and local pressures, said MacLure, provide incentives to shorten lengths of stay and decrease ancillary services and volume on "high intensity" cases, and to increase outpatient services and volume on "low intensity" cases. Pressures for mergers and multi-institutional arrangements will be strong, MacLure predicted, resulting in increased competition among hospitals. These same pressures, however, have the potential to produce conflicts between the hospital and medical staff, because fee-for-service medical payment is now in conflict with the new incentives for hospitals. Medical staff will need to be involved with management in the decision-making process, and the trustees will be called upon to make the policy decisions necessary for NEDH to successfully adapt to the changes that Chapter 372 will bring.

"The challenges represented by Chapter 372 are significant," continued MacLure, "and many changes in the way we manage our hospital are undoubtedly going to occur over the next several years . . . I am confident that the Deaconess can and will meet these challenges and will emerge as a stronger institution still committed to high quality patient care," he concluded.

Following the business session and a short trustee meeting, dinner was served by the dietetics department staff in the NEDH cafeteria.

Conversing before dinner is served in the Deaconess cafeteria are (l - r): James F. Farr, trustee and former chairman of the board; L. Tillman McDaniel, MD, internal medicine; George M. Hughes, clerk of the corporation; and Hubert D. Sycamore, assistant director.

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Transplant *(continued from page 1)*

"In general, short-term survival (one to two years) of a living-related (from a living blood relative) kidney transplanted into a person who has diabetes, is as good as transplantation into a person without diabetes," said Dr. Anthony P. Monaco, head of the transplantation division, department of surgery. "Quality of life for these patients is improved dramatically, and if a transplant fails, the person can return to dialysis and await a second transplant," observed Dr. Monaco.

The NEDH renal transplantation program, which began in 1968, currently performs about 50 transplants annually, establishing the hospital as a leader in this field throughout the New England region. Nearly 50% of these patients have diabetes. The transplant team, under the direction of Dr. Monaco, includes Deaconess/Joslin Diabetes Center renal specialists, and Deaconess surgeons, Drs. Peter N. Madras and Anthony I. Sahyoun.

The survival rate for transplanted cadaver kidneys is 70% after one year, and 60% after two years. For living-related renal transplants, the survival rate is 88% after one year, and 85% after two years. Dr. Monaco points out that the surgical procedure of transplantation is not technically difficult — "the problem is in obtaining the organ for the patient, and in persuading the body to keep it," he said.

The best transplant results for diabetic and nondiabetic people are achieved from using living-related kidneys. Dr. Monaco and Renal Transplant Nurse Patricia Conway mention the possibility of finding a family donor during their initial meetings with the patient and his family to discuss transplantation.

"No one solicits donors," Conway firmly states. "Whatever the family decides, we do everything in our power to help them follow through with their decision. I always tell them, 'it's hard to say "yes" or "no" to a relative who needs a kidney'," she said. Patients may not ask for help from their families out of fear of rejection. Other relatives might dissuade a prospective donor from giving a kidney because of misconceptions regarding the procedure. And after the transplant, the donor might feel that the patient owes him something in return, or he may try to control the patient's behavior. Conway finds that in the majority of situations she encounters, the relationship between donor and recipient is strengthened, and that the donor feels an increased sense of self-esteem from having donated.

Beverly Haberman, 39, did not have to ask her family to donate — all six siblings offered to give a kidney to their sister. The family came into the NEDH Blood Bank to undergo simple blood and *tissue typing tests* to determine donor compatibility. Two brothers were perfect "matches." Beverly Haberman met with Conway and Dr. Donald G. Miller, Deaconess/Joslin renal specialist, to ask questions before surgery. "The most important thing to me was, 'would I feel better?' I didn't anticipate a longer life expectancy," said Haberman, who has diabetes and is blind. "I asked if a transplant would change my eyesight. I was grasping at straws," she said. "They replied that they could practically guarantee that a transplant would not affect my eyesight. They tell you right off that it is a treatment, not a cure," said Haberman.

Her brother, 52-year-old Donald Haberman, had no second thoughts about giving a kidney to his sister. "I knew I would be the one selected. I would have been disappointed if I wasn't the one," recalled Haberman. The day after the operation, Haberman visited his sister. "Don told me that the kidney was a gift, and when you give someone a gift, it is no longer yours, it belongs to the person to whom you gave it," explained Beverly Haberman.

Seeing what a transplant has done for his sister, Donald Haberman has decided to donate his organs to an organ bank when he dies. "I think more people should do so. It makes you feel good to know that you will be able to help someone live a normal life," he said. "I look at my sister now — her voice is strong, she goes out dancing, her attitude has changed — it's like the difference between night and day."

Beverly Haberman did not feel happy or elated immediately after the transplant — she felt sad and guilty for not having a "better attitude." "Pat Conway told me that I shouldn't expect myself to react in a certain way because I had a new kidney," said Haberman. "She reminded me that I was the same person I was before surgery, and I shouldn't let other people pressure me into being different than what I am." Haberman has found that the transplant has liberalized her diet and given her more energy — dialysis had left her exhausted and ill. Divorced, with an 8½-year-old daughter, Haberman is trying to fill the void caused by her leaving a teaching position two years ago when she became blind. She plans to seek vocational training through the Massachusetts Commission for the Blind.

"We are anxious to get transplant patients back into the work force," Conway commented. "If need be, physicians write letters to employers assuring them that a transplant does not affect a person's ability to work. And if that person needs vocational or rehabilitation training, we try to arrange that for them, too."

The connection with the Deaconess and Joslin staffs does not end with surgery. For the rest of their lives, transplant patients must take strong immunosuppressive drugs — substances which make people more susceptible to viruses and infections, a definite risk factor for those with diabetes. Also, there is no safe cut-off point guaranteeing a transplanted kidney's permanent success. A kidney can deteriorate slowly over a period of years, a process which is detected by blood and urine tests performed during monthly clinical visits to the Deaconess.

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Glossary

Diabetes Mellitus: A disorder of the body's metabolism, involving insufficient production of insulin (a hormone) by the pancreas. As a result, sugars and starches are not properly processed by the body. Instead, the body breaks down fat and muscle to use as a substitute energy source. The sugars and starches accumulate in the blood, causing a person to feel weak, lose weight, and to urinate, drink and eat excessively. Diabetes cannot be cured, but it is manageable through dietary control, medication and/or injections of insulin.

Dialysis: The process of separating two solutions by a porous membrane. The basic principle and structure of artificial kidney machines have not changed since the 1940s when they became the first effective substitute for a human organ. Within the hemodialysis machine, a cellophane sheet divides two compartments — one containing blood from the patient, the other a cleansing fluid called dialysate. The cellophane — a semipermeable membrane — permits movement of microscopic waste products and excess fluids from the blood to the dialysate which is drained from the machine. In peritoneal dialysis (PD), the patient's abdominal covering (peritoneum) is used as the dialyzing membrane, and the dialysate is flushed into the abdominal cavity and removed through a catheter (tube). People with diabetes who undergo continuous ambulatory peritoneal dialysis (CAPD) place their daily insulin requirements into the dialysate, thus avoiding injections and improving blood sugar control in many cases.

Fistula: In hemodialysis treatment, a fistula is a surgical connection which joins an artery and a vein beneath the skin's surface. A needle is inserted through the healed tissue to initiate the dialysis process.

Immunosuppressive drugs: Powerful medications must be taken daily in order to suppress the body's own immune system and to minimize rejection of the transplanted organ. The drugs, however, weaken the patient's ability to resist infections — a serious risk for people with diabetes. The drugs also can have unpleasant side effects, such as a significant weight gain, puffiness around the face and intensified mood swings. Many transplant patients do suffer from some degree of kidney rejection, which can be stopped or slowed by medication. Deaconess/Joslin transplant patients who have diabetes are educated thoroughly in methods of lessening these possible side effects. Patients are instructed and encouraged to maintain an adequate diet and exercise program, aggressive control of blood glucose levels, and careful monitoring of immunosuppressive drugs.

Kidney (renal) transplantation: The process of surgically implanting a human donor kidney into a person whose own kidneys have permanently ceased to function. The transplanted organ can be obtained from a living-related donor (a relative of the patient), or from a deceased (cadaver) donor. In either situation, the transplanted kidney must be tested to ensure that it will match the tissue characteristics of the person who will receive it.

Renal failure: Renal disease can be caused by a variety of factors including infection, blood circulatory disorders, and blockages or abnormalities of the kidney tissues or urinary tract. These conditions often can be treated by dietary adjustments, medication and surgery.

Uremia (meaning "urine in the blood") occurs when waste products build up in the body, indicating that the kidneys are diseased or damaged and no longer can function. Acute (short-term) or chronic (permanent) renal failure requires immediate dialysis treatment to remove waste materials from the body. In the case of acute failure, temporary dialysis gives the damaged kidneys a chance to recover and resume their function. Chronic failure, however, is irreversible.

Dialysis does not supply the hormones that kidneys normally would produce, nor does it filter the blood as well or as continuously, but artificial kidneys are essential for survival. The only alternative to dialysis is renal transplantation.

Tissue typing: Simple blood and tissue typing tests must be done before a kidney is transplanted into a patient. The purpose of these tests is to identify and match as many genetic factors as possible in the white blood cells of both the recipient and the donor, and to determine whether the recipient's immune system will reject the living-related or cadaver donor's kidney. Since people inherit their tissue types, family members make the best possible donors for transplant patients.

Kidney donor facts

"Kidney donation does not restrict or interfere with your lifestyle in any way. After recovery from surgery, you can work, drive, participate in sports, etc., as usual. The average hospital stay after surgery is 7–10 days; most people can return to work in 4–6 weeks. For most donors, the cost of the surgery and pre- and postoperation expenses are paid for by Medicare."

"It does not interfere with a woman's ability to have children. It does not change your life expectancy, nor does it increase your chances of acquiring kidney disease. The remaining kidney will enlarge and do the work of both. Kidney disease usually affects both kidneys, except in the case of tumors, stones or severe injury from an accident. However, you are *no more likely* to develop a tumor or stone, or have a severe accident, with one kidney than with two."

— from "Kidney Donor Facts" National Kidney Foundation of Massachusetts, Inc.

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When medical problems develop and hospitalization is required, people with renal transplants usually are admitted to the Deaconess renal cluster unit on Palmer 2. If the unit is full and renal patients must be sent to other floors, they often request a transfer to Palmer 2 when a bed is available. "The nurses do an incredible job," said Conway, who supervises the education of nurses and patients and their families in the area of renal transplantation. "I'm on Palmer 2 for limited time periods," continued Conway, "but those nurses are on the line every day, caring for people with complex medical conditions." Dr. David C. Yoburn, NEDH/Joslin renal specialist, reinforces the observation. "Residents eventually rotate off the floor, but the nurses are there when and if the patients are readmitted. They know those patients like a book," he said.

Under the supervision of Head Nurse Barbara Howell, Palmer 2 nurses care for a variety of renal patients — people who have been newly diagnosed with renal failure and need *fistulas,* dialysis patients with complications, pre- and post-transplant patients, and those with other renal diseases. Most of the patients have diabetes, a factor which requires sophisticated and diligent nursing care. There are many repeated admissions to the floor, a situation which can be stressful for the nurses.

"It's not like a general medical/surgical floor where patients come in acutely ill, are treated, and go home to recover," explained Pamela Roberto, RN. "You do see many of the transplant patients go home looking and feeling so much better. But for the most part, you look for small improvements and celebrate small victories. And you have to learn to accept the choices they make regarding their treatment and support them in those decisions — it's their lives," she concluded.

Janet Larsen, RN, whose mother learned how to dialyze herself through the hospital's hometraining program, said that, "although patients have similar problems, you can't compartmentalize them," she said. Having seen her mother cope with renal disease, Larsen has a particular empathy with what her patients are experiencing. "Newly diagnosed patients often are scared and angry," explained Larsen. "The physicians, nurses, social worker and chaplain schedule a group meeting with the patient and family to discuss treatment alternatives for the patient," she continued. "Our education effort often is geared towards the entire family."

Since people with permanent renal failure do need medical treatment throughout their lives, family and friends often become involved in assisting them to manage their disease. Renal cluster and dialysis nurses play a major role in this education effort, which can include making the hospital environment less threatening for the children of people with renal failure. A nine-year-old daughter of one dialysis patient attended hometraining sessions with her mother, who said that the child is now able to set up and dismantle peritoneal dialysis equipment, "she completely floored the doctors and nurses with her skill," recalls her mother.

Palmer 2 nurses remark that patients often become like family to each other, and to the people who care for them. "Some people say it's not professional to get emotionally involved, but you have to in a sense," explained Caroline Hastie, RN. "When patients feel you really care, they will confide in you, which enables you to help them better. You learn how to set your limits."

When those limits are strained too far, nurses can turn to other renal team members for support. Chaplain Raymond Anderson meets with the nurses to give them an opportunity to vent their frustrations and fears, to discuss their experiences, and to seek counsel and moral support.

Renal Social Worker Suzanne Piening visits with Michael Schultz, who recently received a kidney transplant.

"Listening and being present are my primary tasks on the renal team," said Anderson. "I'm there not only for patients and their families, but also for physicians and nurses involved in the patients' care," he continued. "Those who come to know a patient in a very caring and intimate way over a long period of time also need to be ministered to when the patient has a setback in his treatment, or if he dies. The staff also experiences grief and loss," remarked Anderson.

Anderson recounted the time he and a Deaconess social worker attended a former dialysis patient's funeral. They sat with the patient's family during a luncheon held for family and friends following the funeral. "It was a way for us to grieve over the loss of a young man," remembered Anderson. "For his family, our presence seemed to symbolize that the hospital was more than an institution; it was a community of people who really cared about their son, and about their loss," Anderson said.

Patricia Conway, who worked for many years with dialysis patients before becoming a renal transplant nurse, said that she is fortunate in having been able to see both sides of working with people who have renal failure and diabetes. "You tend to forget that many people do well medically in coping with the diseases. I see transplant patients during clinical visits — weeks, months and years after they have received a transplant," said Conway. "Once I read something about caring for chronically ill people which always has stuck in my mind — 'you must care when cure is impossible.' Sometimes the best thing you can do for people is to be there, to sit with them, and to listen."

The problems of renal transplantation

Finding a donor

The need for organ transplants is a desperate one for thousands of people across the country who eventually will die or will be severely incapacitated by progressive heart, liver or kidney disease. People with failing kidneys often are able to receive a kidney from a family member, since a person can live with only one kidney. But those requiring other vital organs and tissues must seek help from regional organ banks — independent agencies established across the country to procure, preserve and distribute cadaveric organs and tissues.

Recent publicity concerning Jamie Fiske, the baby from Bridgewater, Massachusetts, who received a liver transplant, helped to promote increased awareness of the constant and urgent need for organ donations. Residents from many states can donate their organs and other body parts for the purpose of transplantation or research by filling out a simple form attached to their motor vehicle driver licenses.

The possibility of organ donation, however, usually arises at an inopportune and emotionally difficult time — when family members have learned that a relative is near death, or has died. The attending physician makes the preliminary inquiries to the family. NEDH transplant surgeon Anthony P. Monaco, MD, who is president of the New England Organ Bank, emphasizes that the family is not coerced into making a decision.

"Often, the hospital's nursing staff, chaplain, social worker, and/or a representative from the organ bank, are requested to answer questions regarding the legal, medical, ethical and religious concerns of the family," he explained. "Many people feel comforted that, despite their irreplaceable loss, others have been given a chance to live or to improve the quality of their lives through the donation." said Dr. Monaco.

A letter of acknowledgement and appreciation is sent to the donating family by the organ bank. Recipients are not informed of the donor's identity, except for the basic facts of sex and age. The donating family receives the same information.

In the case of someone who needs a cadaver transplant, the patient's name and monthly results of blood/tissue typing tests are entered into the regional organ bank's computer. When an organ is available, the computer matches it with the most appropriate recipient in the immediate region. If a compatible recipient is not found nearby, the organ must be sent to another location in the country, or a person from a foreign country who needs a transplant might be advised to travel here for the transplant. Organs must be used within 72 hours of removal from a body.

Preventing rejection

"The major problem in renal transplantation is in preventing rejection of the implanted kidney," explained Mary Wood, research associate at the Deaconess. "We have some very good immunosuppressive drugs now, but the aim of all researchers is to achieve what we call a 'tolerance' to the transplant in the recipient," she said. "This is accomplished by manipulating the human immune system in such a way that the recipient would be able to reduce greatly his requirement of immunosuppressive drugs."

For many years, transplantation research has taken place in the NEDH Cancer Research Institute under the direction of Dr. Anthony P. Monaco, scientific director of the institute. Currently, the research team includes: Mary Wood; Drs. Takashi Maki, Frank Pomposelli, Shohei Minami; James J. Gozzo, PhD; Rita Gottschal, technician.

The researchers are using inbred mouse strains to study ways to prevent the rejection of skin grafts and to induce "tolerance" to the foreign graft. They have found that the injection of low doses of bone marrow, whole blood or platelets from the graft donor into recipient mice treated with a minimal amount of immunosuppression will prolong significantly the survival of the graft. The mice require no further immunosuppression after grafting — if they receive cells from the grant donor.

"Applied clinically, the theory is that by giving bone marrow, platelets or blood from the graft donor to the recipient, specific suppressor cells in

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News in Brief

Several members of the NEDH medical staff contributed to the *Textbook on Internal Medicine* recently published by Little, Brown & Co.: **Robert C. Moellering Jr., MD,** chairman of the department of medicine, wrote on the principles of anti-infective therapy; **Adolf W. Karchmer, MD,** head of the infectious diseases section, wrote on infections of the joints; **Z. Myron Falchuk, MD,** contributed sections on hospital infection control and hospital-acquired pneumonia.

Dr. Ellison C. Pierce Jr., chairman of the department of anaesthesia, was named president-elect of the American Society of Anesthesiologists (ASA) at the society's annual meeting in Las Vegas this past fall. Dr. Pierce also has served the ASA as first vice president of the organization, and as chairman of the committee on clinical forum.

At its annual meeting in Orlando, Florida, the American Society for Therapeutic Radiologists (ASTR) elected **Samuel Hellman, MD,** director of the Joint Center for Radiation Therapy, as president of its 1,800-member organization for one year. The ASTR is responsible for representing radiation therapy's position in organized medicine within the American College of Radiology and the American Medical Association, and for providing an annual scientific meeting.

William V. McDermott, MD, chairman of the department of surgery, gave a paper on the results of surgical intervention on pancreas division at the recent annual meeting of the New England Surgical Society. **Randolph B. Reinhold, MD,** surgeon, also presented a paper on the management of malignant ascites with peritoneovenous shunting (surgically creating a passageway in veins of the peritoneal cavity to drain accumulated fluid caused by cancer).

Donald Miller, MD, medical director of the NEDH Diabetes Treatment Unit at the Joslin Diabetes Center, spoke on the clinical experience in treating people with diabetes using continuous ambulatory peritoneal dialysis (CAPD) during the White Mountains CAPD Symposium in Lincoln, New Hampshire, on March 8.

During February and March, several Deaconess physicians lectured at the 1982-1983 continuing medical education program of the Faulkner Hospital's department of anaesthesia: **Dr. Joseph D. Zibrak,** of the pulmonary disease section, spoke on prevention of postoperative respiratory complications; **Dr. Antoine Kaldany,** nephrologist at the Joslin Diabetes Center, discussed renal failure in diabetic patients; **Dr. Albert Bothe Jr.,** assistant to the chairman of surgery, talked about liver transplants.

Chief of Podiatry **Geoffrey Habershaw, DPM,** recently spoke on diabetic foot infections during foot rounds at the department of orthopedics, division of podiatric medicine at the University of Massachusetts Medical Center in Worcester.

Renal Dietitian Specialist **Susan Levine, RD,** was the featured presenter at a one-day course on nutritional aspects of permanent renal disease, sponsored on February 17 by Franklin Square Hospital, Baltimore, Maryland, and the Health and Education Council. Levine spoke to dietitians, pharmacists and physicians on the assessment of patients with permanent disease, and the special dietary considerations of people who have diabetes and renal disease.

Director of Volunteer Services **Phyllis Wasserman** was a guest speaker and workshop leader at the recent New England Association of Hospital Directors of Volunteer Services Conference held in Woodstock, Vermont. Wasserman spoke on the use of the transitional volunteer in a hospital volunteer program.

Joyce Tower, director of the dietetics department, was a member of a panel of nutritional professionals who discussed nutrition career possibilities during Nutrition Career Night, sponsored by the Simmons College Department of Nutrition and Nutrition Liaison.

John Connelly, director of security, recently passed the Massachusetts Bar examination after graduation from New England School of Law.

NEDH and Harvard Medical School have announced establishment of the **Irving J. Walker Memorial Fund** which primarily will benefit the academic goals of the NEDH Department of Surgery. The fund was made possible through a bequest by Dorothy Walker, widow of Irving J. Walker who served as clinical professor of surgery and chief of the Harvard surgical service at Boston City Hospital from 1931 to 1940 and contributed significantly to the field of abdominal surgery. Presently, the fund will provide a fellowship for **Roger Jenkins, MD,** of the Deaconess department of surgery, to continue his academic work in the field of transplantation.

Alumnae, save this date!
Saturday, October 29, 1983, has been selected as the 15th Annual Alumnae Reunion Day for the School of Nursing. Remember to mark this date on your calendar. Program information and a registration form will appear in future issues of PULSE.

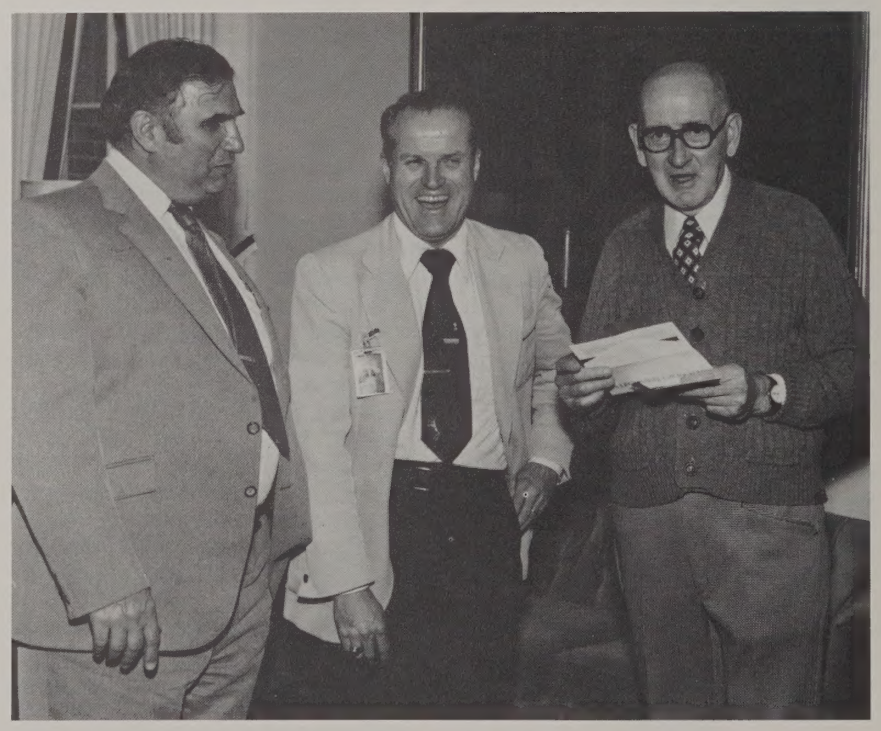
NEDH security officers receive certification

In a special ceremony on Harris Hall 5, friends and family joined NEDH staff in congratulating six hospital security officers who were certified recently by the International Association for Hospital Security after completing a year-long training program. The graduates and guests included (standing, l to r): NEDH Director of Security, John T. Connelly; Kevin Connors; Leonard Moniz; Daniel Davis; Paul Estey; NEDH Assistant Security Manager James McMahon; (seated, l-r): James Dennis; Sally O'Connor; John Jenkins.

The program is tailored to sensitize security officers to the hospital's service environment and the unusual security problems a hospital can present. According to NEDH Security Director John T. Connelly, the program was made available only to a select group of individuals "who demonstrated dedication to their work, and whom we believed would benefit most from the program." The course was taught by personnel from the NEDH Security Department and First Security, Inc.

A little girl named Torrey exemplified the unusually sensitive security problems found in the hospital environment when she wrote a letter to a Deaconess security guard, saying, "Thank you for going and looking for my mitten. My Dad got very mad and you settled him down."

Dolan retires after 12 years at NEDH



After 12 years as a Deaconess building services aide in the evenings, John Dolan (above right) said goodbye to friends at his retirement party on February 25 in the Harris Hall Livingroom. The hospital presented Dolan with a $75 gift certificate to the Lechmere stores. Joining Dolan in the celebration were Richard Delaporta (l), senior assistant to the director for management engineering, and Dean Annis, assistant director. Several days prior to this daytime celebration, the staff of the building services department's evening shift threw a going-away party for Dolan and presented him with a gold watch. "John rarely missed a day of work in years," said David Fordham, building services evening/night services coordinator. "He was friendly, dedicated and very conscientious." In addition to his job, Dolan also was a dedicated donor to the Deaconess blood bank. In June 1982, they honored him as a two-gallon donor.

Dr. Bern receives Tullis Award at Annual Medical Alumni Meeting

Murray M. Bern, MD, chief of the NEDH hematology section, received the James L. Tullis, MD, Lectureship Award for his work on "endothelial phenomena in coagulation" at the NEDH Medical Alumni Annual Meeting in Joslin Auditorium.

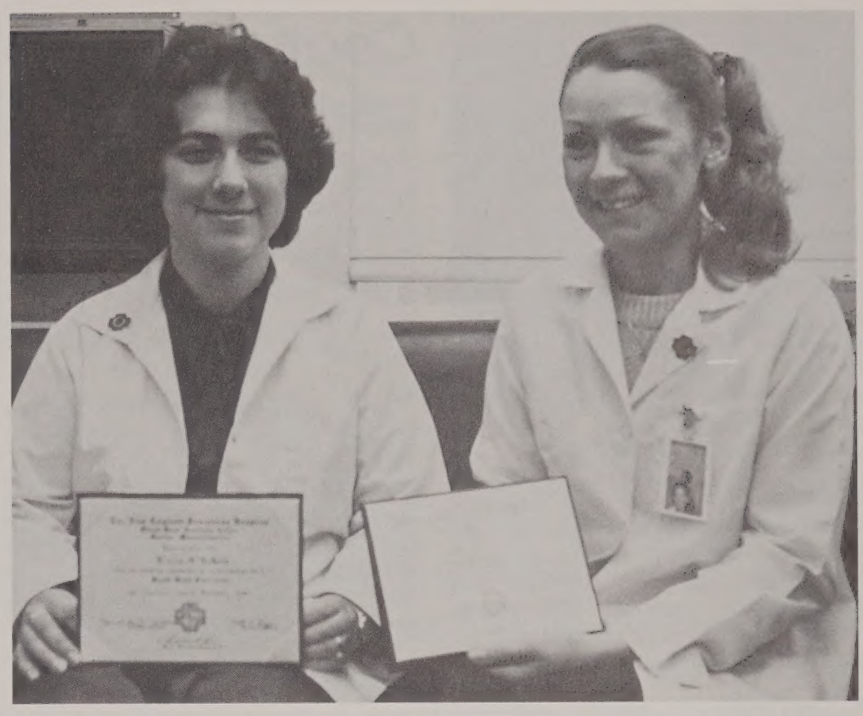
The Tullis award, named after the former chairman of the Deaconess department of medicine, was established in 1977 to honor notable research in the medical, psychological or sociological fields.

The goal of Dr. Bern's work is to identify mechanisms that explain or monitor changes in coagulation of the blood that lead to thrombosis (clots in the blood vessels) which can contribute to atherosclerosis (degenerative disease of the arteries). Two areas of investigation concern endothelial cell functions and inhibitors of clotting (i.e., antithrombin III).

Two other alumni of the NEDH Department of Medicine's residency program also presented scientific papers on their work in hematology research at the alumni meeting. Thomas Hill, MD, head of the Deaconess nuclear medicine department, spoke on assessing cerebral (brain) blood flow regulation. The second presenter, Richard L. Edwards, MD, assistant professor of medicine at the University of Connecticut School of Medicine, was back in Boston to speak on procoagulant activity of monocytes (type of blood cell) and the link between coagulation, inflammation and neoplasia (new growth or tumor development).

After presentation of the scientific papers, Director Richard E. Lee described future projects that the Deaconess is investigating, such as a sleep disorders clinic, pain clinic and pancreatic and liver transplants. The meeting adjourned to a dinner honoring visiting professor, Daniel Federman, MD, dean for students and alumni at the Harvard Medical School.

Department of Medicine Chairman (r), Robert C. Moellering Jr., MD, presents Dr. Murray M. Bern, chief of the hematology section, with the James L. Tullis, MD, Lectureship Award for his work in "endothelial phenomena in coagulation". Dr. Bern received the award during the NEDH Medical Alumni Annual Meeting held in Joslin Auditorium.



Two graduate from blood bank program

Elaine Ruback (l) and Maria Mach recently completed the NEDH Blood Bank Specialists Program, a one-year course of theoretical and practical work, which qualifies them for the national certification examination for Specialist in Blood Banking. The first course of its kind in New England, the program enables students to obtain credit towards their medical laboratory science degree while attending Northeastern University. Enrollees in the 12-year-old program have several years of blood banking experience and are medical technologists of the American Society of Clinical Pathologists.

Dr. Meissner named to honorary medical staff

President Laurens MacLure presents William A. Meissner, MD, with a scroll appointing him to the honorary medical staff in recognition of his 40 years of service at the Deaconess . A surgical pathologist, Dr. Meissner was chairman of the department of pathology from 1963 to 1972, and served as president of the medical staff and the medical administrative board. In 1976, the Deaconess dedicated its laboratory and radiation therapy building in honor of Dr. Meissner, who is internationally known for his studies on the thyroid gland. The NEDH medical staff voted to appoint Dr. Meissner to the honorary staff because of his "innumerable major contributions to the growth and development of the hospital, its department of pathology and its residency program." Membership on the honorary staff is conferred on retired physicians and dentists who have rendered noteworthy service to the hospital, or who have attained special distinction in their fields of practice.

Tilley "retires" as coordinator for Friends of the Deaconess

President Laurens MacLure thanks Jane Tilley (far right) for her dedication as activities coordinator for the Friends of the Deaconess during one of her "not-exactly" retirement parties held on February 15 in the Harris Hall Livingroom. Dorothy Seccomb, past president of the Friends (second from left) and Gladys Fullerton, membership chairperson, joined the festivities to congratulate Tilley on her retirement after five years, but also welcomed her back as a volunteer in the same office. MacLure noted that Tilley's endless supply of energy has been a moving force behind many of the Friends' projects — coordinating everything from Christmas bazaars to furniture sales — to help raise thousands of dollars for diagnostic and therapeutic hospital equipment, NEDH School of Nursing scholarships and interior improvements in hospital buildings.

In the photo at right, Alan Kelson, maintenance and engineering (r) and Benjamin Martino, security, entertain guests at an earlier retirement party for Tilley, given by the Friends on December 16, 1982.

Marti Hopkins, RN, head nurse of the diabetes treatment unit at Brookline Hospital.

Cooperative outreach ventures benefit NEDH and communities

Four diverse neighborhoods — Roxbury, Brookline, Mission Hill and The Fenway — touch the Deaconess Hospital's boundaries. In turn, the Deaconess touches them, through cooperative outreach ventures that benefit both the communities and the hospital.

In Roxbury and in The Fenway, the Deaconess helps support neighborhood health centers that play integral roles in the provision of health care in those communities. In Brookline, the Deaconess has assisted Brookline Hospital in setting up novel intensive care and diabetes treatment units — novel because NEDH staffs them. And in Mission Hill, the neighborhood bus transportation system remains in service because NEDH and other community organizations help underwrite the neighborhood's annual fund-raising fair.

All these efforts are particularly important to the Deaconess because NEDH is set apart from the other hospitals in the Longwood medical area. Whereas community residents may be familiar with other area hospitals through emergency rooms or obstetric and pediatric services, NEDH has none of these more common entrances into a hospital. Because it is a specialty-referral hospital, patients rarely walk in off the street. Through outreach efforts in the surrounding communities, the Deaconess becomes a more visible and viable provider of medical care.

"Deaconess administration recognizes the importance of building a system of linkages with other health care institutions," said Associate Director David F. Lilley, who coordinates the NEDH community outreach efforts. "We consider our affiliations to be an important commitment. Many people at NEDH have put a lot of time and effort into developing programs and making them run effectively."

Roxbury Dental and Medical Group

The hospital's oldest community affiliation has been with the Roxbury Dental and Medical Group (RDMG), a nonprofit, community-based health center owned and directed by its patients.

RDMG provides obstetrics, gynecology, pediatrics, adult primary care and dentistry, among other services, and holds special clinics on family planning, childbirth and nutrition. Adults who need hospitalization come to the Deaconess; children go to the Children's Hospital Medical Center.

A major portion of the center's clientele is elderly, but pediatric visits are increasing. Between 85 and 95% of the patients are black, and the remaining patients are Portuguese or Spanish-speaking. Approximately 65% of Roxbury's patients have Medicaid, which means the center is paid a predetermined fee for services, a figure which does not necessarily meet the actual cost of providing those services.

RDMG began in 1969 as a small, storefront medical group established by a Deaconess surgeon, Dr. W. Bradford Patterson, and internist Dr. Donnel Boardman. Within a year, the physicians were approached by community groups expressing a desire to have a voice in meeting the medical care needs of their community.

By 1971, what started as a private enterprise had become a community corporation with a board of directors. NEDH Director for Community Medicine at the time, Dr. Randolph B. Reinhold, became RDMG's first executive director and continued in that role for five years. The group needed an association with a hospital, however, so it approached NEDH. The Deaconess became an inpatient facility for RDMG patients, and admitting privileges were extended to RDMG physicians not previously on the hospital staff. NEDH also provided monetary support.

"RDMG was unique," said Dr. Reinhold, "because it was one of the few centers in the country that tried, by choice, to provide quality medical care for low-income people in the city without federal funding, and with limited financing from private sources and the Deaconess." Today, NEDH is the largest single source of nonpatient revenue (30% of the annual budget), according to Katherine Samples, MD, medical director of RDMG.

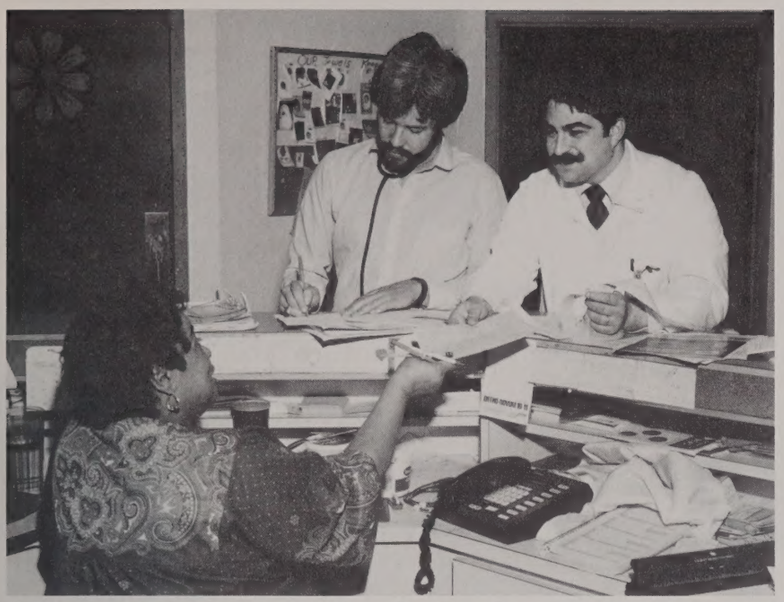
(continued on next page)

Employees receive service award pins

Director Richard E. Lee (l) and President Laurens MacLure (r) visit with 20-year employee Albina R. Satkowiak (l), nursing service, and 15-year employee Jane E. Erskine, observation unit, during a recent service awards ceremony held in the Harris Hall Livingroom. During the coffee hour, employees received service award pins in recognition of their 5, 10, 15, 20 or 25 years of service to the hospital.

TEN-YEAR RECIPIENTS: *(back row, l-r) Patricia Rossetti, surgical services; James Abercrombie, building services; Angela Grassa, Deaconess surgical fund; (front row, l-r) Audrey Jacome, intensive care; Hildred Chester, Carolee Keene, nursing service.*

FIVE-YEAR RECIPIENTS: *(back row, l-r) Lois H. Mangan, surgical services; Catherine Randall, pathology; Gordon H. McKissock, messenger service; (front row, l-r) Janet L. Schiff, pathology; Richard Tranfaglia, Lowry Medical Office Building; Betty Kariotis, building services; Helen W. Webb, nursing service.*



Malcolm Rosenson, MD, second-year medical resident (r), reviews results of a patient's laboratory tests with Phyllis Jefferson (l), x-ray technician at Roxbury Dental and Medical Group, as Harlan Gibbs, MD, also a second-year medical resident, completes notations in a patient's medical record.

(continued from page 8)

"Generally, each health center has an affiliation with a hospital and operates under the hospital's license and budget," explained Dr. Samples. "Roxbury is somewhere in between. We receive funding from the Deaconess as part of the city's matching program (the city's department of health and hospitals gives a matching amount up to a certain dollar limit), but we are independent in that we have our own license, are an independent corporation and have our own board of trustees," she pointed out.

Since 1971, the Deaconess has committed not only money, but time and people, to RDMG. In the early 1970s, nine Deaconess physicians, representing six subspecialties, supported RDMG by providing medical coverage one-half day per week with no salary.

Today, Deaconess medical support for RDMG is provided by eight medical residents who rotate through the health center one-half day per week during their three-year residencies. NEDH is primarily an inpatient hospital, but medical residents are required by the Accreditation Council for Graduate Medical Education to obtain outpatient medical care experience. "Clearly, the beginning of the NEDH residency training program for outpatient medicine at RDMG (in 1975) was a benefit for the hospital in its relationship with the health center," said Dr. Reinhold. "As the Deaconess grew in the role of a teaching hospital," he observed, "it became a necessary element in the hospital's teaching program."

"The medical residents help provide continuity of care," added Dr. Samples. "They have their own patients, and if any of those patients need hospitalization, the physicians can follow through with them at the Deaconess."

Malcolm Rosenson, MD, second-year medical resident, has practiced at RDMG for 18 months and sees it as an educational experience, not only medically, but also in human terms.

"I get exposure to the protocol of an outpatient office setting and become familiar with outpatient care, while the Deaconess provides me mostly with inpatient care," said Dr. Rosenson. "Roxbury has a large population which has different types of health problems. Not only am I exposed to their medical problems," explained Dr. Rosenson, "but how those problems impact on their lives. Often, for example, money becomes a predominant factor in whether a patient will — or can — comply with prescribed medical treatment."

In addition to residency training, RDMG provides first- and second-year students from the NEDH School of Nursing with ambulatory experience in obstetrics and gynecology, clinical settings which the Deaconess cannot provide. Also, the nurses at RDMG participate in continuing education programs for nurses at NEDH.

"We hope that, out of this experience, Deaconess residents and nursing students will be more sensitive to working in the community and might decide to come back and work here," emphasized Dr. Samples. "And because we are involved in the teaching program," she added, "it helps recruit quality medical staff members who become instructors for the students."

Beyond direct medical care, the Deaconess has shared with RDMG the services and skills of a dozen hospital departments during the last 11 years, including accounting and office systems development, laboratory and radiology procedures, maintenance and engineering assistance, supplies, and public relations support. Today, the Deaconess continues to provide data processing services to the center.

"RDMG is important to the community because it provides needed primary care where private practice medicine has not succeeded," Dr. Samples pointed out. "It is a local industry that employs community people and is an advocate for preventive health care in the community. We are the only health care center that has this type of affiliation with the Deaconess," Dr. Samples noted "and patients come to us because of it."

Fenway Community Health Center

About the time the RDMG was flourishing, another sort of health center was evolving in the Fenway neighborhood. The Fenway Community Health Center had its beginnings in a basement — where it remains today — as a free health center with volunteer staff. A high turnover of physicians and lack of money for supplies hindered the center, however, so the founders turned to hospitals in the Boston area for assistance.

Internists at the Deaconess decided to provide coverage one afternoon a week, and the NEDH offered financial support under the city's matching grant program. During the next decade, fee structures were introduced, medical and administrative staffs hired, and now 17,000 people routinely seek the center's services.

Although outside medical staff is no longer needed at the Fenway center, the Deaconess continues to help financially and provides certain supplies and maintenance assistance.

"The goal for a health center is to become more independent and the Fenway Community Health Center has done just that," said NEDH Associate Director David F. Lilley.

Fenway's patient population differs greatly from that in Roxbury. The elderly make up only 12% of the patients — most patients are between the ages of 20 and 35. Approximately 65% are homosexual.

Most of Fenway's patients do not qualify for public assistance (Medicaid) or are too young for Medicare, so they have to pay for their health care out of their own pockets. "We are a leader in caring for patients with sexually transmitted diseases (STD), and are the only facility in the country that combines treatment for STD with routine primary care," said Sally Deane, executive director of the Fenway Center. "We make primary care accessible," she continued. "It is the most affordable health care in the area and our hours are convenient. Most people would not get this care if we didn't have this accessibility."

Brookline Hospital

Accessibility and continuity of care at reasonable costs are priority issues for the health care community as a whole. Due to the rising costs of health

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Network exists between Deaconess and other New England hospitals

Communication between the Deaconess Hospital and greater Boston communities is one aspect of hospital outreach activities. Another is communication between Deaconess medical staff and physicians in outlying New England hospitals.

The communication system established through clinical affiliations has two major components, explained Jacob J. Lokich, MD, chief of the Deaconess medical oncology section, the staff of which has established relationships with several hospitals in Massachusetts and southern New Hampshire. The first component is the delivery of specialized, sophisticated care within the community itself. The second is a continuing education exchange with community physicians.

"Cancer treatment technology, for example, is a dynamically evolving field," explained Dr. Lokich. "It is important, therefore, that there be communication between specialty-referral centers, like the Deaconess, and community hospitals, so that new developments within the field can be transferred rapidly to patients in the local community."

One day a week, for instance, NEDH oncologists practice at the St. Luke's Hospital tumor clinic in New Bedford, and once a month, oncologists attend tumor conferences at three New Hampshire hospitals: Wentworth-Douglass, Dover; Frisbie Memorial, Rochester; Portsmouth, Portsmouth. "We are providing community hospitals with expertise right in the patient's own setting," said Dorothy M. Ross, NEDH Clinical Marketing Representative. "Only a very small percentage of patients actually need to come to Boston.

"Patients with certain diseases always will need intense, special (tertiary) care not available at general hospitals," explained Ross. "Our physicians see many such cases — heart surgery, transplants, gastric surgery — unlike community physicians who may see a few of these cases during their entire practice. In addition, our doctors are exposed to the latest research and drugs not readily available in outlying communities," she concluded.

Some of the Deaconess continuing education programs in the community — the second component of clinical affiliations — have been in progress for years, as has the 25-year-old weekly educational series given by Deaconess physicians at Monadnock Community Hospital in Petersborough, New Hampshire.

"We have a 90 percent turnout every week for nine months because of the quality of the speakers and the topics discussed," said Glyn Millard, MD, chairman of the Monadnock Community Hospital's postgraduate education committee. "We would like to extend the program to 12 months a year."

Other education affiliations are more recent, as is the year-long lecture series established this year with the Springfield Academy of Medicine in Holyoke. Arranged through the NEDH Department of Surgery, the series will cover a broad range of topics and will feature physicians from the Deaconess departments of surgery and medicine.

"We hope to pursue additional affiliations with community hospitals," said Ross, "in order to continue this exchange of knowledge and skills that ultimately benefits our own patients as well as patients in local communities, and which helps the Deaconess to fulfill more effectively its mandate as a teaching hospital."

Community *(continued from page 9)*

care ($267 billion nationally in 1981), however, the emphasis on cost control — efficient and effective use of health care services — has become the first priority for health care providers and administrators.

Three years ago, the Deaconess and neighboring Brookline Hospital established a working affiliation that advanced this priority. Brookline Hospital, which has 109 beds and serves mostly surrounding communities, began to refer patients needing more specialized care to the Deaconess which, in turn, referred appropriate admissions to Brookline. This was mutually beneficial to both hospitals, helping reduce NEDH's long waiting list, while improving Brookline's occupancy rate.

In January 1981, an unusual contract was drawn up between NEDH and the Brookline Hospital, which provides for the staffing and nursing management of the intensive care unit at Brookline, by Deaconess nurses.

More recently, with a waiting list at the NEDH Diabetes Treatment Unit (DTU) at the Joslin Diabetes Center (JDC), the two hospitals and JDC drew up an agreement for a ten-bed DTU, staffed and managed by nine Deaconess nurses and located at Brookline. For the first ten months of its existence, the DTU has been filled to capacity. "A real plus of this program," said Brookline Hospital Director Raymond D. Sanzone, "is that it sets groundwork for other kinds of relationships between community hospitals and teaching institutions, which can share programs effectively and efficiently and deliver a good level of patient care."

The Brookline diabetes treatment unit is modelled after the 70-bed Deaconess DTU at Joslin. The Deaconess coordinates the booking of patients and maintains a system to transport patients and medical records between the three institutions. NEDH also provides a foot care service for people with diabetes.

The Joslin Diabetes Center provides medical supervision of the unit, teaching nurses, and a nutritionist to contribute to the education of the DTU patients. Brookline hospital supplies the space, dietetic and ancillary services, and equipment.

The average length of stay for DTU patients is one week to learn how to regulate and manage their disease. The patients, however, differ from patients in the DTU at Joslin since they generally are between 30 and 65 years old. "The Brookline unit is smaller than the DTU at Joslin, so patients get even more individual attention," explained Marti Hopkins, RN, head nurse of the unit. "Lots of learning takes place between patients, and good support systems develop. Patients love it here," she added. "They like the intimacy."

Sharing resources besides direct patient care

The Deaconess extends itself to the community in ways beyond direct patient care. For three years, the Deaconess, along with 100 other local community groups and institutions, has helped underwrite the Mission Hill Fair, which funds the Mission Hill "link" bus transportation system. At the fair, the NEDH Public Relations Department, in collaboration with members of the nursing, blood bank and personnel departments, presents an exhibit with free screening for high blood pressure and diabetes, blood typing and job counseling for the health care field.

Motivating interest in health and the health care field also is the purpose of a collaboration between the Deaconess volunteer services department and Action for Boston Community Development (ABCD). For the past five years, NEDH has participated in ABCD's health careers opportunity program, which allows interested high school juniors and seniors from economically disadvantaged households to find summer employment in the health care field. The students work three days a week at NEDH under the supervision of Phyllis Wasserman, director of volunteer services, and the ABCD staff. "No matter where they work in the hospital," said Wasserman, "the students gain a greater understanding of medicine, patient care and health care job opportunities."

In yet another outreach effort, students in the NEDH Dietetic Internship program rotate for one month at the Mattapan Community and Codman Square health centers, and the Francis Stearn Nutrition Clinic at the Tufts New England Medical Center.

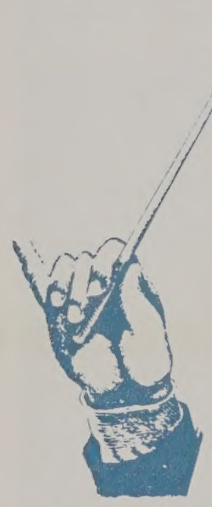
Whether it is people from the community coming to the Deaconess, or the Deaconess going out to them, the hospital's commitment to quality medical care and the public's general well-being is not limited to its 14 buildings and 489 beds. It extends that commitment to thousands of people outside its doors — a majority of whom will never see the inside of a Deaconess building.

Renal *(continued from page 5)*

the recipient will be activated," explained Wood. "The recipient's immune response will be specifically suppressed to tissue of the graft donor, and his body will not reject the graft."

In the past, physicians have avoided transfusing blood into patients before transplant surgery, fearing that the organ would be rejected. Today, however, many hospitals are transfusing patients with blood in preparation for receiving living-related or cadaver organs. Studies have found that such transfusions have had a beneficial effect on transplant survival.

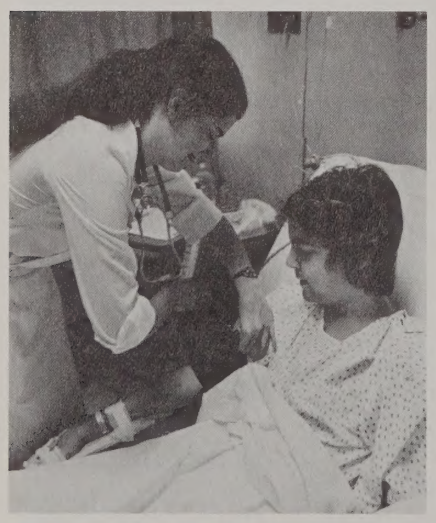
"We have demonstrated that these results are due to activation of suppressor cells, but we are not exactly sure how it happens," commented Wood. "Scientists know that even in a normal response of the immune system, when lymphocytes (white blood cells) destroy bacteria and other foreign materials, suppressor cells are present to 'shut off' the immune response when it has performed its function," she elaborated. "Our goal is to make the suppressor cell response the dominant one, rather than the immune response, so that the graft is protected. If we succeed, patients will be able to reduce dramatically their constant requirement of immunosuppressive drugs."



Save the date

Deaconess Night at Pops
Monday, May 16, 1983

To obtain an order form for "Deaconess Night at the Pops" tickets, call Beth Weingarten, in the Friends of the Deaconess office, at (617) 732-8044.



Transplants help patients lead less restricted lives (see page 1)

Outreach ventures benefit NEDH and communities (see page 8)

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